STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00090843. Complaint IN00090843: Substantiated, State Residential findings related to the allegations are cited at R006. Survey dates: June 14, 15, & 16, 2011 Facility number: 004458 Provider number: 004458 Aim number: N/A Survey team: Janet Adams, RN Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 14 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 6/21/11 Cathy Emswiller RN	R0000	**Submission of this response & Plan of Correction is NOT a legal admissions that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in this response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0006	(f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.			
	Based on observation, record review, and interview, the facility failed to ensure the safety needs of 2 of 2 residents with repeated falls in the sample of 14 were met as the residents remained in the facility after sustaining multiple falls in the facility. Residents #B and #C) Finding include: The Resident Move In Binder was reviewed on 6/15/11 at 2:00 p.m. The Move In Binder was provided to resident's upon admission and contained	R0006	**R006** **Corrective Action Taken:** **It is the practice of Settlers House to ensure a resident is discharged if the resident requires 24 hours per day comprehensive nursing oversight and has not entered into a contract with an appropriate licensed provider, is not medically stable and requires total assistance and the facility cannot meet the resident's needs.** **Resident B is presently in a skilled nursing facility receiving rehabilitation services therefore unavailable for assessment.** **Resident C receives licensed**	07/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	information about the facility policies and procedures. There was a Residency Agreement in the Move In Binder. The Residency Agreement had a revised date of 2/2008. Section IV titled 'TERMINATION OF THE RESIDENCY AGREEMENT" indicated "The Residence may terminate this Agreement upon thirty days (30) days written notice to You for one of more of the following reasons: a. Your health has improved sufficiently so that You no longer need the services provided by the Residence; b. Your safety or the safety of others in the Residence is endangered; c. Your health or the health of others in the Residence would otherwise be endangered; d. Transfer or discharge is necessary for Your welfare and Your needs cannot be met by the Residence; e. Nonpayment of fees, after reasonable and appropriate notice; or f. The Residence ceases to operate as a Residential Care Facility. 1. The record for Resident #B was reviewed on 6/14/11 at 11:05 a.m. The resident was admitted to the facility on 7/30/10. The resident's diagnoses included, but were not limited to, mild dementia, high blood pressure, history of falls, depression, and prostate cancer.		**home health services by a registered nurse 2-3 per week and personal care 3 times per week by a home health aid. She is also receiving physical and occupational therapy services. Resident C's family is satisfied with her care, and desires she stay at Settlers House. The family has increased their visits to daily for companionship.** **Resident C's physician has signed her monthly orders which state that she is appropriate for Assisted Living. He has also signed an order stating that she is medically stable.** **Resident C has a seat and tab alarm in place to remind her of the need to refrain from trying to get up. She has pendant to call for assist. She was moved to a room proximate to the front of the facility. Staff checks the resident as assigned.** **<u>Identification of Other Residents:</u>** **Residents with similar needs will be identified by the Assessment and Service Plan. The Physician's Plan of Care that is completed for admission certifies that the resident does not need continuous skilled nursing and is appropriate for assisted living. Monthly orders also certify that the resident does not need continuous skilled nursing and continues to be appropriate for assisted living.** **Residents who are identified with similar needs will have Home**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a Mini Mental Status Examination completed on 1/28/11 indicated the resident scored a 21 out of 30. The scale indicated a score of 24 or above was considered normal. A "Global Deteriorations Scale For Assessment of Primary Degenerative Dementia" was completed on 1/28/11. The resident was assessed to be at Level 3. Level 3 indicated the presence of "Mild cognitive decline (Mild Cognitive Impairment)." Review of the 2/1/11 Nursing Comprehensive Evaluation indicated the resident was forgetful and had a diagnosis of mild dementia. A hospital "Inpatient Clinical Summary" dated 6/2/11 indicated the resident's discharge diagnosis was listed as altered mental status. A hospital History and Physical report dated 5/30/11 indicated the resident was alert and orientated x 2 with noticeable forgetfulness. An "Assessment and Negotiated Service Plan Summary" was completed on 11/17/10. The Service Plan indicated the resident needed staff to administer or to supervise self administration of medications. The Service Plan indicated the resident utilized a walker and electric wheelchair or scooter. The Service Plan also indicated the resident had period of		**Health services by a licensed agency including RN, Home Health Aid and therapy if indicated. Those who are identified as appropriate for Hospice will have services provided by a licensed Hospice agency.** **Assessments and Service Plans have been reviewed by the Regional Director of Quality and Care Management, and appropriate supportive services are in place.** **<u>Measures Put in Place:</u>** **Medical instability and increased needs will be identified by the Wellness Director, RN designee and/or physician.** **Appropriate supportive services by a licensed Home Health Agency or Hospice will be secured.** **Staffing levels and assignments will be adjusted to meet the needs of the residents.** **The attending physician will be consulted regarding medical stability and any additional orders for care.** **The facility has a fulltime RN who is also on call 24hr per day and lives 10 minutes away. QMA's and CNA's are assigned to each shift based on the resident needs.** **The licensed Home Health Agency or Hospice contracted to provide additional services has appropriate supportive staffing managed by a RN.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	anxiety An "Assessment and Negotiated Service Plan Summary" was completed on 5/5/11. The Service Plan indicated the resident needed assistance to bathe and shower and received services from a Home Health Service. The Service Plan also indicated the resident had a history of falls and a history of a fracture as the result of a fall, and the resident had fallen in the last month. The resident also used assistive devices of a walker, manual wheelchair, and an electric wheel chair or scooter and needed reminders to use his assistive devices. A "Nursing Comprehensive Evaluation" was completed on 2/2/11. The Evaluation indicated the resident required assistance with eating, toileting, transferring, ambulation, bathing, hygiene, and dressing. A "Negotiated Risk Agreement" was completed by the facility and signed by the resident on 9/15/10. The agreement noted " The parties wish to negotiated an agreement regarding risks You may undertake contrary to the Residence's practice or advice. The purpose of this Agreement is to identify Your needs that will not be met by the Residence and Your Preferences that are contrary to the		**Monitoring of Corrective Action:** **The Regional Director of Quality and Care Management will review the assessments of residents who are dependent for ADLs during routine visits monthly to ensure that appropriate interventions for the residents at risk are in place. The Regional Director of Operations will review staffing levels as related to service needs at least 2 times weekly by monitoring a company report that is issued daily.** **The Safety Committee will meet monthly and review fall risks and any occurrences during the month and suggest further interventions as needed. The Residence Director will fax a copy of the minutes to the Regional Director of Operations monthly for review.** **Monitoring will take place as an ongoing Quality Assurance process.** **Date of Compliance: 07/16/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Residence's recommendations for You, to assess the potential harm resulting from those unmet needs or preferences, and to identify and negotiate mutually agreed upon courses of action to address Your unmet needs and preferences and the responsibilities of You and the Residence." The agreement also noted "You understand and agree that independent activities and responsibility for personal, financial, and health care decisions may involve risks of personal injury and/or property damage or loss. You and the Residence have used your best efforts to identify all conditions, situations, or preferences that are or should be known to the Residence that involve a course of action taken or desired to be taken by You contrary to the practice or advice of the Residence and which could put You at risk of harm or injury...." The "EXHIBIT" attached to the above Negotiated Risk Agreement indicated the resident had a history of self ambulation without staff assistance and has been informed several times to have staff assistance for transfers and ambulation. The resident was to use the call light/pendant for staff notification for all ambulation and transfers, take slow steady steps, and not to rush with ambulating. The exhibit indicated the staff were to answer the call system in a reasonable			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	time and to assist the resident with transfers and ambulation with the use of a gait belt at all times. The 2/2011 Resident Service Notes were reviewed. An entry made on 2/20/11 indicated the resident was found on the floor on his buttock and the resident had no complaints of pain. The resident was re-educated to ask staff for help. An entry made on 2/25/11 at 6:00 p.m. indicated the resident was found lying on the floor in his room by the CNA. The resident stated he was trying to pick up a coin. No injury was noted. An entry made at 9:00 p.m. indicated the resident was re educated on safety issues and use of the pendent. An entry made on 2/26/11 at 1:55 p.m. indicated the Nurse was called to the resident's room by the CNA. The resident was lying on the floor with his left leg flexed. Skin tears were noted to the resident's left hand measuring 1.8 cm (centimeters) x 1.2 cm and 1.3 cm x 1 cm. The resident was re educated on the use of the call light, pendant and pull cord in bathroom. The resident denied pain or discomfort. The "Residence Director Incident Report with Root Cause Analysis" for 2/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was reviewed. An entry made for 2/20/11 indicated the resident was found on the floor in front of a chair. Causal factors listed on the report indicated the resident stated he missed thee chair and had recent medication change that increased instability. Interventions listed on the report were to remind the resident to ask for assistance. An entry made on the above report for 2/25/11 indicated the resident was found on the floor in front of a chair. Causal factors were listed were that the resident stated he was bending over to pick up a coin. Interventions listed were that the resident was given pendant for use to ask for assistance. An entry made on the above report for 2/26/11 indicated the resident was found on the floor in front of a chair. Causal factors were listed as resident family states "attention seeking behavior." Interventions listed were to remind the resident for ask for help. Spoke to the family. The 3/2011 Resident Service Notes were reviewed. An entry was made on 3/2/11 at 8:30 a.m. This entry indicated the resident fell when walking back from the dining room after breakfast. The resident was re educated on safety issues of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	walking himself and staff asked the resident to always ask for assistance. The 4/2011 Resident Service Notes were reviewed. An entry made on 4/2/11 at 9:45 a.m. indicated the resident was found on the floor in the bathroom in his room. The resident stated he "lost his balance while on the toilet...." A skin tear was noted on the resident's left elbow approximately 1/2 inch in diameter, a bandage was applied and the bandage stopped the bleeding. The resident was reminded to use the pendant or call system when he needed assist. An entry made on 4/25/11 at 5:05 a.m. indicated the resident pulled the bathroom cord and was found lying on the bathroom floor on his back. The resident said he slid on the floor. The resident had no complaints of pain or apparent injury. The "Residence Director Incident Report with Root Cause Analysis" for 4/2011 was reviewed. An entry made on 4/2/11 indicated the resident had an unwitnessed fall and stated he lost his balance when getting off of the toilet. Causal factors listed were that the resident will not ask for help and states he gets dizzy sometimes. Interventions were to remind the resident to use the pendant and to take time when getting up.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

An entry made in the above report on 4/25/11 indicated the resident had an unwitnessed fall and was found on the bathroom floor. Causal factor listed were that the floor was slick in the bathroom. Interventions listed were for the facility to order replacement tile for the bathroom and to remind the resident to use the pendant.

The 5/2011 Resident Service Notes were reviewed. An entry made on 5/20/11 at 4:30 p.m. indicated the resident went to sit on his bed and slid off the bed onto the floor on his buttocks. The resident was able to move all his extremities and denied any pain.

The 6/2011 Resident Service Notes were reviewed. An entry made on 6/2/11 at 4:30 p.m. indicated the resident was found on the floor in his room on his buttock. The resident was encouraged to use the call light/pendant with all transfers. An entry made on 6/9/11 at 4:45 p.m. indicated the resident fell when he was walking with his walker in the hallway. The resident hit his head in the doorway and a "big gash" was noted to the back of the residents head. Staff called 911 services and the resident was sent to the hospital emergency room. An entry made on 6/9/11 at 9:00 p.m. indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was admitted to the hospital. When interviewed on 6/15/11 at 9:00 a.m., the facility Administrator indicated the Residence Director Incident Report with Root Cause Analysis logs were done monthly and those for May 2011 had not been completed at this time. Medical records obtained from the hospital the resident was taken to on 6/9/11 indicated the resident had a left parietal scalp hematoma and lacerations of the left elbow following a fall. The records also indicated a History and Physical obtained on 6/9/11 noted the resident was brought to the hospital Emergency Room after a fall at the Assisted Living facility and the patient stated he had been having multiple falls . The History and Physical also indicated the resident had a history of a right hip intertrochanteric fracture, right shoulder surgery, and a history of a right proximal humerus (arm) fracture in the past. The History and Physical indicated the resident had tenderness of the right forearm, laceration to the left elbow and a laceration to the scalp which was repaired. The physician indicated the resident was found to be orthostatic (demonstrating a decrease in vital signs upon movement). The "Emergency Documentation" records			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident had a skin tear to the left elbow and a laceration to the back of the head which measured 22.0 cm (centimeters) in length and 2.0 cm in with sanguineous (bloody) drainage. There was no documentation in the resident's record of the facility initiating any plans to transfer or discharge the resident to another facility as the resident's needs for supervision to keep him safe were not met. The resident sustained repeated falls with facility interventions in place. When interviewed on 6/16/11 at 8:50 a.m., the facility Administrator indicated she had went to the hospital Emergency Room on 6/9/11 after the resident fell at the facility. The Administrator indicated she stayed with the resident until he was admitted to a floor in the hospital. The Administrator indicated the resident received staples to his head wound in the Emergency Room. When interviewed on 6/16/11 at 8:40 a.m., the RN Wellness Director indicated the resident had been receiving Home Health services. The services include an RN visit twice a week, Home Health Aide visit twice a week, and Physical Therapy visits twice a week. The Wellness Director indicated the resident was able to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dress himself and walks with staff with the use of a gait belt. 2. On 6/14/11 at 10:45 a.m., Resident #C was observed sitting in wheelchair in the hallway. A music activity was taking place. There was a clip alarm attached to the resident's clothing. The record for Resident #C was reviewed on 6/14/11 at 10:05 a.m. The resident was admitted to the facility on 6/11/10. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, heart disease, and had a history of a left hip fracture with repair in 12/2010. A "Nursing Comprehensive Evaluation" dated 6/1/11 indicated the resident had history of falls with a fracture to the left hip. The evaluation indicated the resident was dependent on staff for toileting, transferring, ambulation, dressing, bathing, and medication management. The evaluation also indicated the resident's memory was impaired and she was incontinent of bowel and bladder at times, had a chair and tab alarm in use, and had a history of falls. An "Assessment and Negotiated Service Plan Summary" dated 6/14/11 indicated the resident was unable to dress and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	groom independently and used assistive devices including a walker and a manual wheelchair. The resident had a fall in the last month and needed the assistance of one person for getting out of a chair or transferring from the chair to the bed, and needed assistance of staff to be escorted or pushed in the wheelchair to move about the residence. The plan also indicated the resident was unable to toilet herself safely and staff were to take her to the bathroom. The "Global Deterioration Scale for Assessment of Primary Degenerative Dementia" completed on 6/6/11 indicated the resident had "Moderate cognitive decline (Mild Dementia)." A "Negotiated Risk Agreement" was completed on 2/2/11 and signed by the facility staff and the resident's family. The agreement noted " The parties wish to negotiated and agreement regarding risks You may undertake contrary to the Residence's practice or advice. The purpose of this Agreement is to identify Your needs that will not be met by the Residence and Your Preferences that are contrary to the Residence's recommendations for You, to assess the potential harm resulting from those unmet needs or preferences, and to identify and negotiate mutually agreed upon courses of action to address Your unmet needs and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	preferences and the responsibilities of You and the Residence." The agreement also noted "You understand and agree that independent activities and responsibility for personal, financial, and health care decisions may involve risks of personal injury and/or property damage or loss. You and the Residence have used your best efforts to identify all conditions, situations, or preferences that are or should be known to the Residence that involve a course of action taken or desired to be taken by You contrary to the practice or advice of the Residence and which could put You at risk of harm or injury...." An "Exhibit" attached to the above Risk Agreement indicated the resident had a history of falls with a hip fracture and repair in 12/2010 and had dementia. Risks and potential consequences of the risks included falls, fractures, including and up to death. Alternates considered or attempted included relocating the resident to a closer room, use of a pendant and call light, staff for all transfers, frequent reminders on safety, and the use of tab and chair pad alarms. The 1/2011 Resident Service Notes were reviewed. An entry made on 1/27/11 at 4:15 p.m. indicated the resident fell while trying to transfer herself. The resident was re-educated on the use of the pendant			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

and call light. An entry made on 1/28/11 at 8:00 a.m. indicated a purple bruise was noted to the resident's right hand on the knuckle area.

The "Residence Director Incident Report with Root Cause Analysis" for 1/2011 was reviewed. The report indicated the resident had a unwitnessed fall on 1/27/11 and was found on the floor in front of a chair. Causal Factors noted were listed as the resident was attempting to self transfer and the resident slid to the floor. Interventions listed included that was a NRA (Negotiated Risk Assessment) in place and the family provided a tab alarm and chair alarm for increase in safety. The resident was to be on frequent safety checks, revised toileting schedule, and encouraged to participate in activities.

The 3/2011 Resident Service Notes were reviewed. An entry made on 3/12/11 at 7:00 a.m. indicated the resident was found lying on the floor in the bathroom.

The "Residence Director Incident Report with Root Cause Analysis" 3/2011 was reviewed. The report indicated the resident had an unwitnessed fall on 3/12/11 at 6:15 a.m. Causal factors listed were confusion, reminded to wait for help. Interventions listed were the resident had a tab alarm and removed shirt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

to stop alarm from going off . Family provided a bed alarm. Staff to toilet x 2 at night and a NRA was in place.

The 4/2011 Resident Service Notes were reviewed. An entry made on 4/6/11 at 5:30 a.m., indicated it was reported that while doing rounds the CNA found the resident in her bathroom lying on the floor on her right side, the resident had removed her shirt with the tab alert attached. A small knot was noted on the back of the resident's head and ice was applied. The resident refused to go the Emergency Room.

The "Residence Director Incident Report with Root Cause Analysis" 4/2011 was reviewed. The report indicated the resident had an unwitnessed fall on 4/6/11 at 5:30 a.m. and was found on the floor in the bathroom. Causal Factors noted were listed as the resident had removed her top that had the personal alarm attached. Interventions included for staff to increase safety checks and to take the resident to the bathroom before and after meals and before bed.

The 5/2011 Resident Service Notes were reviewed. An entry made on 5/18/11 at 1:15 p.m. indicated staff heard the resident's chair alarm going off and went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	into the room and found the resident sitting on the floor next to the recliner. Staff attempted to re-educate the resident on the use of the call light and pendant for all transfers. The 6/2011 Resident Service Notes were reviewed. An entry made on 6/6/11 at 4:30 p.m. indicated the resident was in the bathroom and tried to transfer herself and fell on her buttock. There was no documentation in the resident's record of the facility initiating any plans to transfer or discharge the resident to another facility as the resident's needs for supervision to keep her safe were not met. The resident sustained repeated falls with facility interventions in place. When interviewed on 6/16/11 at 8:40 a.m., the RN Wellness Director indicated the resident required assistance of one for transfers and needs the staff to clean her after incontinence. The Wellness Director indicated the resident received Home Health services with RN visits once a week, Home Health Aide twice a week, and Physical Therapy twice a week. This State Residential tag relates to Complaint IN00090843.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on observation, record review, and interview, the facility to ensure the resident's physician and responsible party were notified of a resident being who slid to the floor during a transfer for 1 of 3 residents in the sample reviewed for physician and responsible party notification of falls in the sample of 14. (Resident #11) Findings include: On 6/16/11 at 9:20 a.m., Resident #11 was observed in a recliner chair in her room. The resident's feet were elevated on the foot rest of the chair. There was a small faded yellowish area to the top both of the resident's feet. During interview at this	R0036	**R036** **Corrective Action Taken:** **PSA involved in incident was required to participate in a retraining regarding lifting safely and also on our reporting practices. During "return demonstration", PSA was deemed to be unsuccessful at 1-person transfers and was terminated.** **Identification of Other Residents:** **No other residents were affected by this deficient practice.** **Measures Put in Place:** **Inservice for staff on procedure for reporting incidents is scheduled for July 12. Inservice will consist of reporting incidents to Residence Director and or Wellness Director, documentation regarding incident, with**	07/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	time, the RN Wellness Director indicated the resident had previously had bruises to the top of both of her feet. The record for Resident #11 was reviewed on 6/15/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to, cataracts and forgetful. A fax information dated 5/30/11 was sent to the physician. This fax indicated the resident had an unwitnessed fall to the floor and slight bruising and swelling was noted to the top of the residents feet. A fax was returned with orders for the resident to have x-rays of both feet. Review of the 5/11 Resident Service Notes indicated there were no entries made on 5/28/11 or 5/29/11. An entry was made on 5/30/11 at 9:00 a.m. This entry indicated bruises were noted to both of the resident's feet and the resident had no complaints of pain. When interviewed on 6/16/11 at 8:30 a.m., the facility Administrator indicated she was first notified of the bruises on 5/30/11 when the resident's family asked how the bruising occurred. The Administrator indicated she started an investigation and interviewed different staff members who had taken care of the resident. The Administrator indicate the		**notification of family and physician noted. Staff to discuss any unusual occurances during daily stand-up meeting. Wellness Director to insure incident is reported to appropriate authorities and documented in NSP.** **Monitoring of Corrective Action:** **Residence Director and/or Wellness Director will review communication log for notations regarding incidents and insure that notifications have been made an ongoing quality assurance process.** **Date of Compliance: 07/16/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA who worked on 5/29/11 informed her that on 5/29/11 the resident slid to the floor when the CNA was transferring the resident. The Administrator indicated the CNA had not told her or any other employees at the time. When interviewed on 6/16/11 at 8:30 a.m., the RN Wellness Director indicated she assessed the resident when she was notified of the bruising on 5/30/11. The Wellness Director indicated she notified the resident's physician on 5/30/11. When interviewed on 6/16/11 at 8:55 a.m., the RN Wellness Director indicated CNA's are instructed to notify the QMA or Nurse on duty of any falls. The Wellness Director indicated the CNA can document in the Resident Service Notes.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, record review, and interview the facility failed to ensure the results of a complaint survey and the plan of corrections to the survey were posted in the State Survey Book at the front desk. This deficient practice had the potential to affect 31 of 31 residents residing in the facility. (Residents #1-#31) The facility also failed to ensure an accident was reported to the RN Wellness Director and the facility Administrator in a timely manner for 1 of 3 resident's reviewed for fall in the sample of 14. (Resident #11) Findings include: 1. On 6/14/11 at 3:05 p.m., the State Survey Book was observed on the counter of the front desk near the main entrance to the facility. The only Survey report in the book was for a State Licensure survey completed on 5/13/10. A Complaint Survey was completed by the Indiana State Department of Health on 1/3/11. The Complaint Survey report with deficiencies cited was not in the Survey	R0090	**R090** **Corrective Action Taken:** **The complaint survey citations and plan of correction for 01/03/2011 was placed in the survey binder by the Residence Director on 06/16/2011 during the survey.** **Staff will be reinserviced on proper reporting protocals on 07/12/2011** **Identification of Other Residents:** **No residents were affected by this deficient practice.** **Measures Put in Place:** **Residence Director will ensure that survey results from ISDH are posted in the survey binder for public record.** **Monitoring of Corrective Action:** **Residence Director and Wellness Director will verify and log that documents are in binder as required by this regulation. During routine regional team visits which occur every 30-45 days, will include verification that survey results are appropriately displayed,** **Date of Compliance: 07/16/2011**	07/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Book. The Plan of Correction to the 1/3/11 Complaint Survey was not in the Survey Book either. When interviewed at this time, the facility Administrator indicated a compliant survey had been conducted in 1/2011. The Administrator indicated the results and Plan of Correction to the deficiencies should have been in the Survey Book as required. 2. On 6/16/11 at 9:20 a.m., Resident #11 was observed in a recliner chair in her room. The resident's feet were elevated on the foot rest of the chair. There was a small faded yellowish area to the top both of the resident's feet. During interview at this time, the RN Wellness Director indicated the resident had previously had bruises to the top of both of her feet. The record for Resident #11 was reviewed on 6/15/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to, cataracts and forgetful. A fax information dated 5/30/11 was sent to the physician. This fax indicated the resident had an unwitnessed fall to the floor and slight bruising and swelling was noted to the top of the residents feet. A fax was returned with orders for the resident to have x-rays of both feet.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the 5/11 Resident Service Notes indicated there were no entries made on 5/28/11 or 5/29/11. An entry was made on 5/30/11 at 9:00 a.m. This entry indicated bruises were noted to both of the rests feet and the resident had no complaints of pain. When interviewed on 6/16/11 at 8:30 a.m., the facility Administrator indicated she was first notified of the bruises on 5/30/11 when the resident's family asked how the bruising occurred. The Administrator indicated she started an investigation and interviewed different staff members who had taken care of the resident. The Administrator indicate the CNA who worked on 5/29/11 informed her that on 5/29/11 the resident slid to the floor when the CNA was transferring the resident. The Administrator indicated the CNA had not told her or any other employees at the time. When interviewed on 6/16/11 at 8:55 a.m., the RN Wellness Director indicated CNA's are instructed to notify the QMA or Nurse on duty of any falls. If the QMA is notified she is to notify the Nurse. The Wellness Director indicated the CNA should have notified the QMA or Nurse. The RN Wellness Director indicated an assessment was completed on 5/30/11.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0148	(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure the building was maintained in clean condition related marred or chipped door frames and walls, dirt on floors, and dried spillage on walls on 2 of 2 resident halls and 1 of 1 dining rooms. (The High and Low Halls) (The Main Dining Room) Findings include: 1. During the Environmental Tour on 6/15/11 at 12:55 p.m., the following was observed on the first part of the High	R0148	**R148** **Corrective Action Taken:** **Areas identified during tour to be repaired and painted. Painting schedule has been implemented and repairs are taking place at this time.** **Identification of Other Residents:** **No residents were affected by this deficient practice.** **Measures Put in Place:** **Routine maintenance check of building for other areas of repair and paint will be conducted. Necessary paint repairs will be addressed.** **Maintenance will be provided with**	07/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Hall: a. The paint on the door frame of the janitors closet was chipped. The door of the janitors closet was marred with black streaks. b. The paint was chipped on the wall by the sink in the bathroom in room 132. The paint on the bathroom door frame was also chipped. Paint on the wall corner near the closet in the room was also chipped and the plaster was gauged. 2. During the Environmental Tour on 6/15/11 at 1:50 p.m., the following was observed on the rest of the High Hall: a. The walls in the bathroom in room 133 were marred. The paint on the bathroom door frame was chipped. b. The wall next to the closet in room 124 was marred. When interviewed at this time, the facility Administrator indicated the above areas were in need of repair. 3. During the Environmental Tour on 6/15/11 at 2:00 p.m., the following was observed on the Low Hall. a. The walls in bathroom in room 116		**a painting schedule, and staff will communicate any new areas to maintenance.** **Monitoring of Corrective Action:** **Residence Director will complete monthly checks of the building to ensure that walls are repaired and painted as needed.** **Date of Compliance: 07/16/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were marred and the paint on the door frame was chipped. b. The paint on the door frame at the entrance to room 108 was chipped. c. The wall paint and plaster were chipped on a corner in the bathroom in room 01. d. The paint was chipped on the corner of the wall near the entrance to the Low Hall. When interviewed at this time, the facility Administrator indicated the above areas were in need of repair. 4. During the Environmental Tour on 6/15/11 at 2:10 p.m., the following was observed in the Main Dining Room: a. There was a buildup of dirt and dust along the wooden baseboard. b. The paint on the door frame of the kitchen entrance was chipped. c. There was streaks of dried food/beverage spillage on the walls next the entrance and the kitchen door. When interviewed at this time, the facility Administrator indicated the above areas			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were in need of cleaning or repair.			
R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure areas in the kitchen were clean related to dust and dirt on sink pipes, ceiling vents and counters. The facility also failed to ensure a system was in place to monitor the cooling down of potentially hazardous foods in 1 of 1 kitchen. This deficient practice had the potential to effect 31 of the 31 residents who received meals from the kitchen. (The Main Kitchen) Findings include: 1. During the Kitchen Sanitation Tour on 6/14/11 at 9:00 a.m., the following was observed: a. There was a build up a dirt and dust on	R0273	**R273** **Corrective Action Taken:** **1.) Identified areas were cleaned on 06/16/2011 during survey.** **2.) Cooling log was implemented on 06/16/2011 during survey.** **Identification of Other Residents:** **No residents were affected by this deficient practice.** **Measures Put in Place:** **1.) Kitchen staff inserviced on use of cooling log and also on findings of this survey.** **2.) Residence Director to conduct monthly sanitation audits in kitchen. During this audit, will check for cleanliness and also will verify that cooling log is being utilized.** **Monitoring of Corrective Action:**	07/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the white plastic pipes under the dishwasher. b. There was an accumulation of dust on the ceiling vent above the food counter. c. The ceiling vent above the three compartment sink was dusty and rusty. There was dust on the sprinkler head. d. There was a build up of dirt and dust on the white pipes below the three compartment sink. e. There was dried spillage on the sides of the white cabinet next to the stove. 2. When interviewed during the Kitchen Sanitation Tour, the Dietary Coordinator indicated when cooked foods are cooled down the food is put into an ice bath until it reaches 70 degrees. The Dietary Coordinator indicated the food is then placed in the cooler at that time and no further temperature monitoring is done. The facility policy from the "Dining Services Resource Guide (2/2010)" was provided by the Administrator. The policy indicated guidelines for heating, cooling, and defrosting must be followed when preparing food. The instructions for "Cooling Hot Foods" indicated that after cooking food that will be refrigerated,		**Residence Director will keep log of audits for review by the regional team during routine 30-45 day visits.** **Date of Compliance: 07/16/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff were not to allow the food to cool to room temperature before storing it in a cooling unit. If food was cooked in a large container, it was to be immediately transferred into shallow pans and refrigerated. The food was then to be stored in this manner until it reaches 41 degrees F (Fahrenheit) and the cooling period was never to exceed 4 hours. Another option for cooling hot food was to place the container in an ice water bath until reaching a temperature of 41 degrees F.			
R0302	(6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview the facility failed to ensure the physician's name was included on over the counter medications administered by the facility for 2 residents in the sample of 14. (Residents #13, and #14) Findings include: 1. The morning medication administration pass was observed on 6/15/11 at 7:40 a.m. QMA #1 prepared several oral medications for Resident #14. The QMA removed a Calcium 600	R0302	**R302** **Corrective Action Taken:** **Wellness Director corrected on 06/16/2011 during survey, ensuring that all OTC medications are marked as per regulation. Pharmacy consultant requested to review regulation.** **Identification of Other Residents:** **No residents were affected by this deficient practice..** **Measures Put in Place:** **QMA to insure all OTC medications are marked as per specification with resident name,**	07/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	milligrams tablet with vitamin D from an over the counter bottle. The QMA also removed a Multivitamin tablet from another over the counter bottle. Both of the bottles were labeled with name of the resident. Neither of the bottles were labeled with the name of the resident's physician. 2. Storage of medication on the Medication cart was observed on 6/15/11 at 2:15 p.m. During interview at that time, the RN Wellness Director identified an over the counter bottle of Multivitamins for Her and a bottle of a stool softener were for Resident #13. Both of the bottles were labeled with the name of the resident. Neither of the bottles were labeled with the name of the resident's physician. When interviewed on 6/15/11 at 3:00 p.m., the RN Wellness Director indicated the physician's name did not appear on the above over the counter medications as required.		**physician name, expiration date and strength.** **Monitoring of Corrective Action:** **RN to audit medication cart weekly to ensure regulation is met.** **Date of Compliance: 07/16/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation , record review, and interview, the facility failed to maintain complete and accurate clinical records for 4 residents in the sample of 14 related to incorrect birth dates and allergies listed on service plans and lack of documentation of a fall. (Residents #2, #6, #7, and #11) Findings include: 1. The closed record for Resident #6 was reviewed on 6/15/11 at 9:45 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, peripheral vascular disease, and presenile dementia. The resident was admitted to the facility on 2/25/11. Review of the 2/25/11 Service Plan indicated the resident's date of birth was 1/1/1900. This was not the date of birth which appeared on the resident's admission information files. When interviewed on 6/15/11 at 3:00	R0349	**R349** **Corrective Action Taken:** **Residence Director corrected Date of Birth on #6 and #7, and diagnosis for #2 identified resident assessments to reflect correct dates of birth and diagnosis as of 06/16/2011 during survey.** **Wellness Director was notified of resident condition on 05/30/2011. PSA was trained to make notes in the resident's service notes of unusual occurances when they occur.** **Identification of Other Residents:** **No other residents were affected by this deficient practice.** **Measures Put in Place:** **Audit will be conducted by the Residence Director of resident assessments to verify accurate information is entered.** **Staff to be trained on reporting and documenting of unusual occurrances on 07/12/2011** **Monitoring of Corrective Action:** **Assessments are reviewed as revised as needed and at 6 month**	07/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., the RN Wellness Director indicated the date of birth on the Service Plan was not accurate. 2. The record for Resident #2 was reviewed on 6/14/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, arthritis, irregular heart beat, and high blood pressure. The resident was admitted to the facility on 6/6/09. Review of the 6/11 Physician Order Statement indicated the resident allergies included, Demerol, Accupril, Zantac, Requip, and Penicillin. Documentation on the 2/28/11 Service Plan noted the resident had no known allegories (NKA). When interviewed on 6/15/11 at 3:00 p.m., the RN Wellness Director indicated the correct allergies should be listed on the Service Plan. 3. The closed record for Resident #7 was reviewed on 6/15/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to, increased anxiety and shoulder fracture. The resident was admitted to the facility on 9/23/10. Review of the 11/23/10 Service Plan indicated the resident's date of birth was 9/22/10. This was not the date of birth		**intervals. The Residence Director will ensure that the information is verified as correct at the time that the assessment is completed.** **Date of Compliance: 07/16/2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	which appeared on the resident's admission information files. When interview on 6/15/11 at 3:00 p.m., the RN Wellness Director indicated the date of birth on the Service Plan was not accurate. 4. On 6/16/11 at 9:20 a.m., Resident #11 was observed in a recliner chair in her room. The resident's feet were elevated on the foot rest of the chair. There was a small faded yellowish area to the top both of the resident's feet. During interview at this time, the RN Wellness Director indicated the resident had previously had bruises to the top of both of her feet. The record for Resident #11 was reviewed on 6/15/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to, cataracts and forgetful. A fax information dated 5/30/11 was sent to the physician. This fax indicated the resident had an unwitnessed fall to the floor and slight bruising and swelling was noted to the top of the residents feet. A fax was returned with orders for the resident to have x-rays of both feet. Review of the 5/11 Resident Service Notes indicated there were no entries made on 5/28/11 or 5/29/11. An entry			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE STREET LA PORTE, IN46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was made on 5/30/11 at 9:00 a.m. This entry indicated bruises were noted to both of the rests feet and the resident had no complaints of pain. When interviewed on 6/16/11 at 8:30 a.m., the facility Administrator indicated she was first notified of the bruises on 5/30/11 when the resident's family asked how the bruising occurred. The Administrator indicated she started an investigation and interviewed different staff members who had taken care of the resident. The Administrator indicate the CNA who worked on 5/29/11 informed her that on 5/29/11 the resident slid to the floor when the CNA was transferring the resident. The Administrator indicated the CNA had not told her or any other employees at the time. When interviewed on 6/16/11 at 8:55 a.m., the RN Wellness Director indicated CNA's are instructed to notify the QMA or Nurse on duty of any falls. The Wellness Director indicated the CNA can document in the Resident Service Notes. The Wellness Director indicated the CNA should have documented the incident in the resident's clinical record.			